This presentation was provided as a Webinar for Health Home Care Coordinators which aired on May 8, 2014. Review of this PowerPoint presentation satisfies, in part, the required State-sponsored special training modules for Health Home Care Coordinators.

This presentation will describe the various Medicare programs and benefits. It will also review the process for filing an appeal with Medicare.

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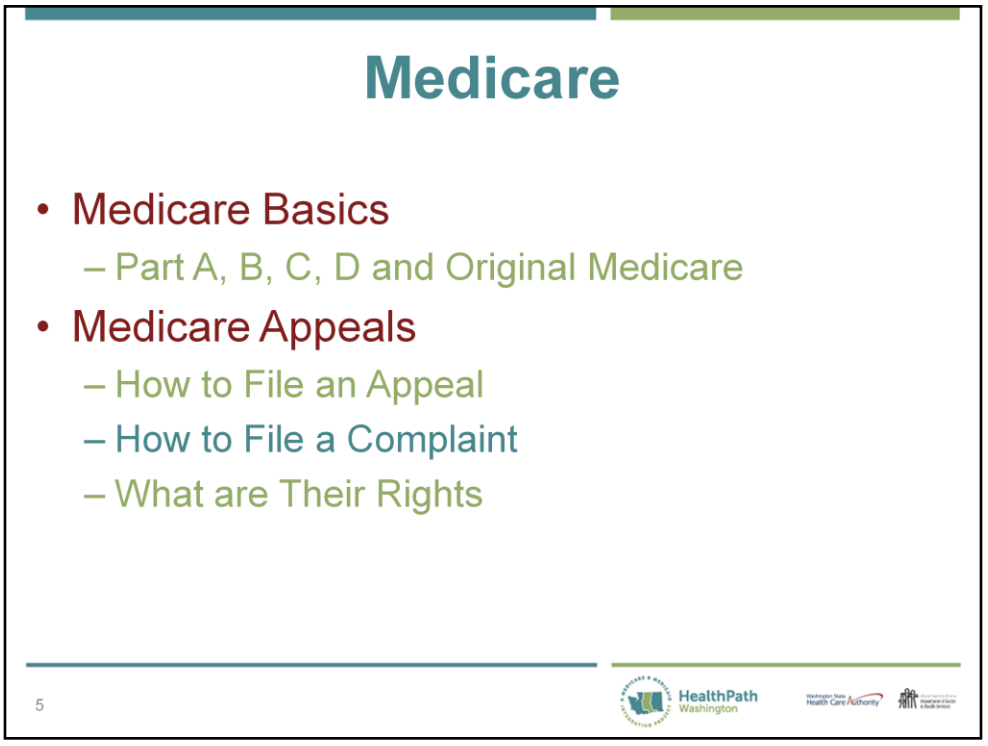
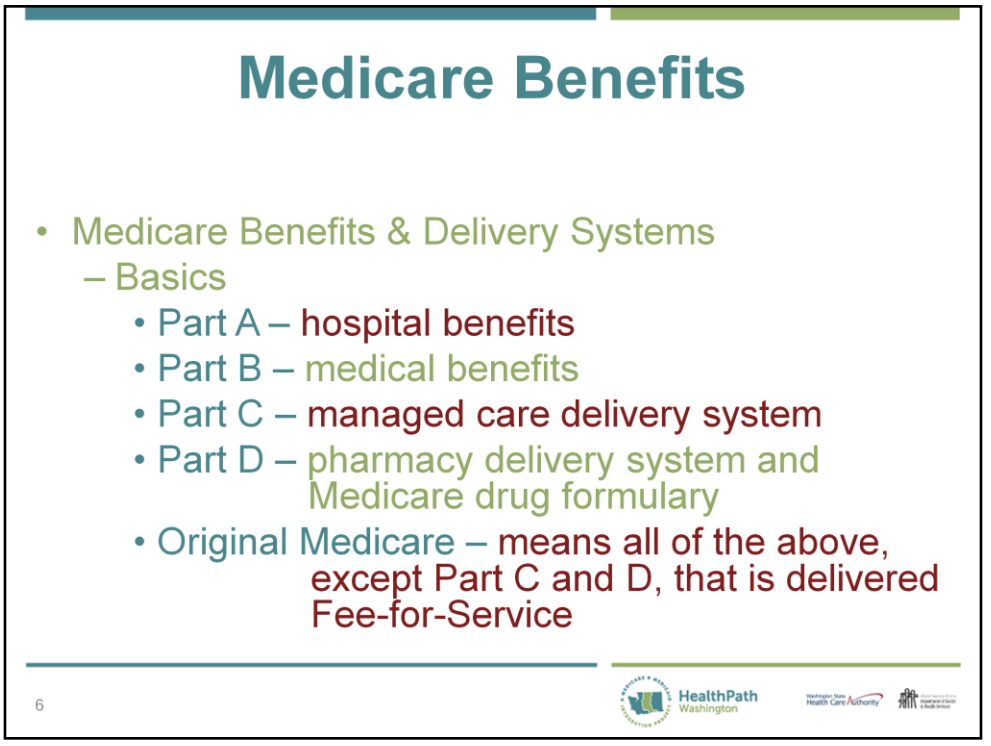
Medicare

Basic Benefits

HealthPath Washington



Before I launch into a description of Medicare's appeal process, I'm going to give you some background on standard Medicare terminology. As the Medicare program progresses into the future, it is revised to include and exclude benefits and it is revised to expand the delivery systems for beneficiaries with Medicare coverage.



I'm not going to spend much time on this section but felt a short tutorial on Medicare terminology may help you when providing services to your Health Home clients. I recommend using the slide show as a cheat sheet.

Medicare is a national medical insurance program, administered by the U.S. federal government since 1966. It guarantees access to health insurance for Americans aged 65 and older who have worked and paid into the system, and younger people with disabilities as well as those with certain medical conditions, such as kidney disease and ALS.
Medicare benefits are broken out into three different categories – Part A is the hospital benefit, which was the first Medicare benefit to be instituted. Part B, which is the medical benefit came shortly thereafter. Part D was instigated the Bush Administration on January 1, 2006 and is used to describe both the delivery system for pharmacy and the pharmacy benefit itself. Part C is the name of Medicare's managed care delivery system and last is what they call "Original Medicare." Original Medicare is their FFS delivery system which is how Medicare benefits were delivered until the advent of Part C and D.

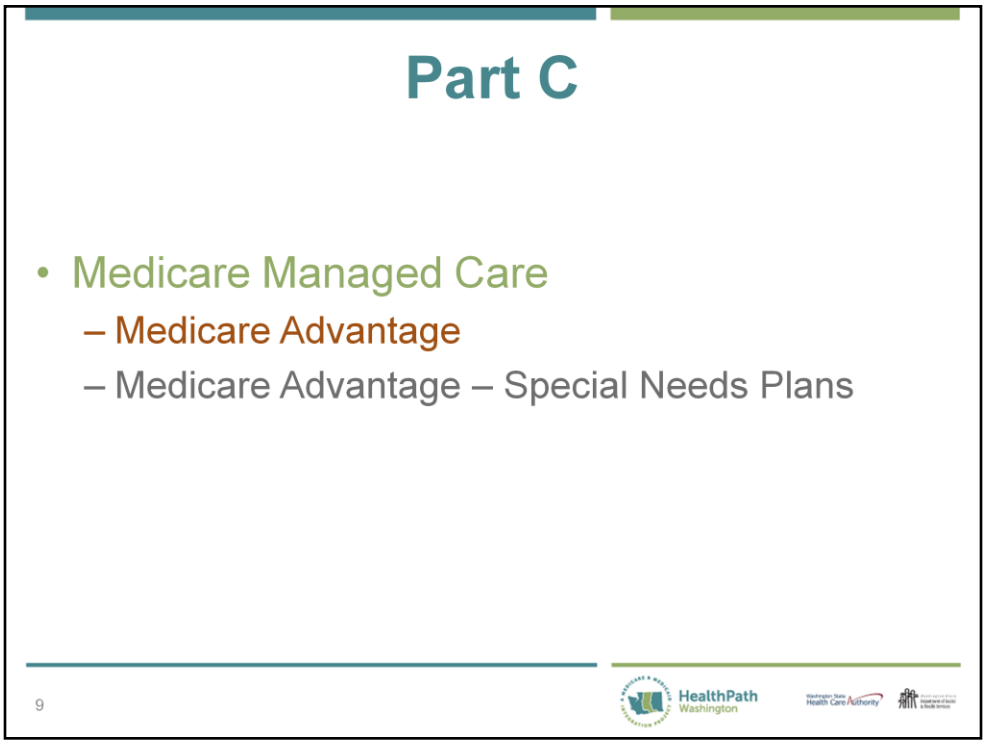
Why is this important? It is important because knowing what it means when someone talks about Part A, B, C, D or original Medicare means you have a better understanding of Medicare and how it works and fits together.

Part A

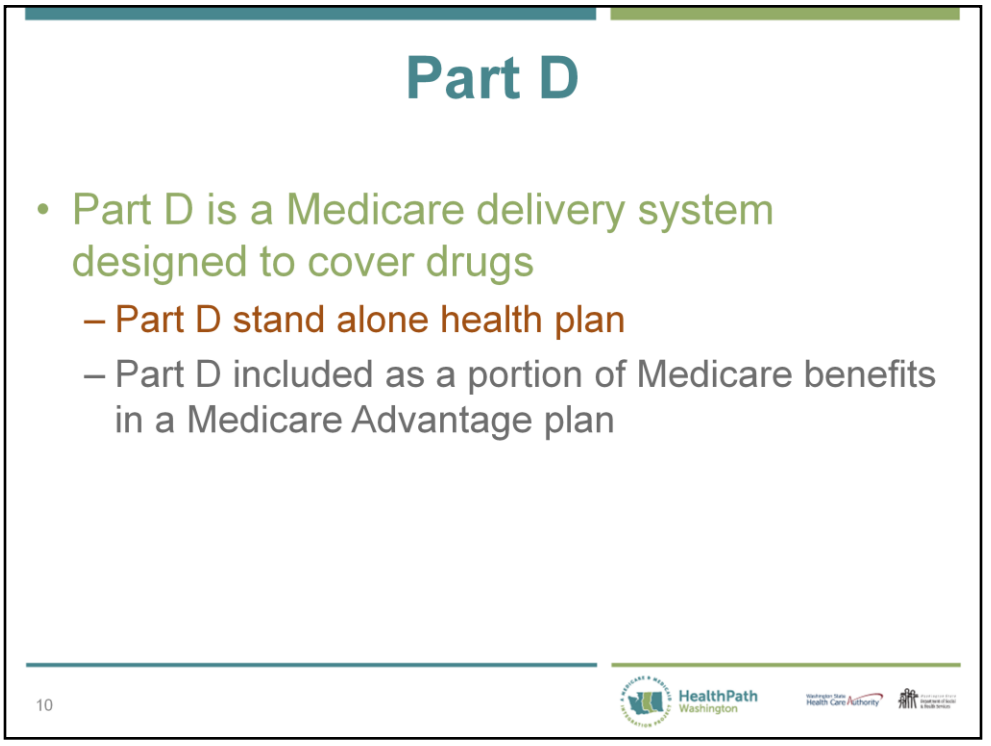
- Part A covers the following:
  - Inpatient care in hospitals
  - Inpatient care in a skilled nursing facility (not custodial or long-term care)
  - Home Health
  - Hospice
  - Inpatient care in a Religious Nonmedical health care institution

Part B

- Part B covers the following:
  - Medically necessary services such as:
    - Doctor services
    - Outpatient care
    - Durable Medical Equipment
    - Other medical services
- Part B also covers many preventive services such as
  - Immunizations



Part C is not a benefit but instead is the term used by Medicare to describe their managed care delivery system. They are a number of different types of Part C plans, but they are all managed care delivery systems.



Part D is newer then A, B and C and is what Medicare calls their pharmacy benefit AND delivery system. Medicare didn't cover drugs under Part A or Part B, except in specific instances, such as getting an immunization at your doctor's office. If that was the case, then the immunization is included in the Part B benefit.

All Medicare beneficiaries are required to have Part D. That doesn't mean your elderly grandmother will be hunted down and forced to comply with the Federal rules. It means that if your elderly grandmother decides that the Federal government isn't going to tell her what to do, then she either pays for the drugs herself, goes without her medication or joins a Part D later then the enrollment period and pays a penalty to join.

Part D may be included as part of the benefits a beneficiary receives when they are in a Part C managed care plan. If their Part C managed care plan doesn't include Part D, then the beneficiary is in a stand-alone Part D plan. Any beneficiary who is on "Original Medicare," (FFS) also receives their pharmacy benefit through a stand-alone Part D plan.

Medicare

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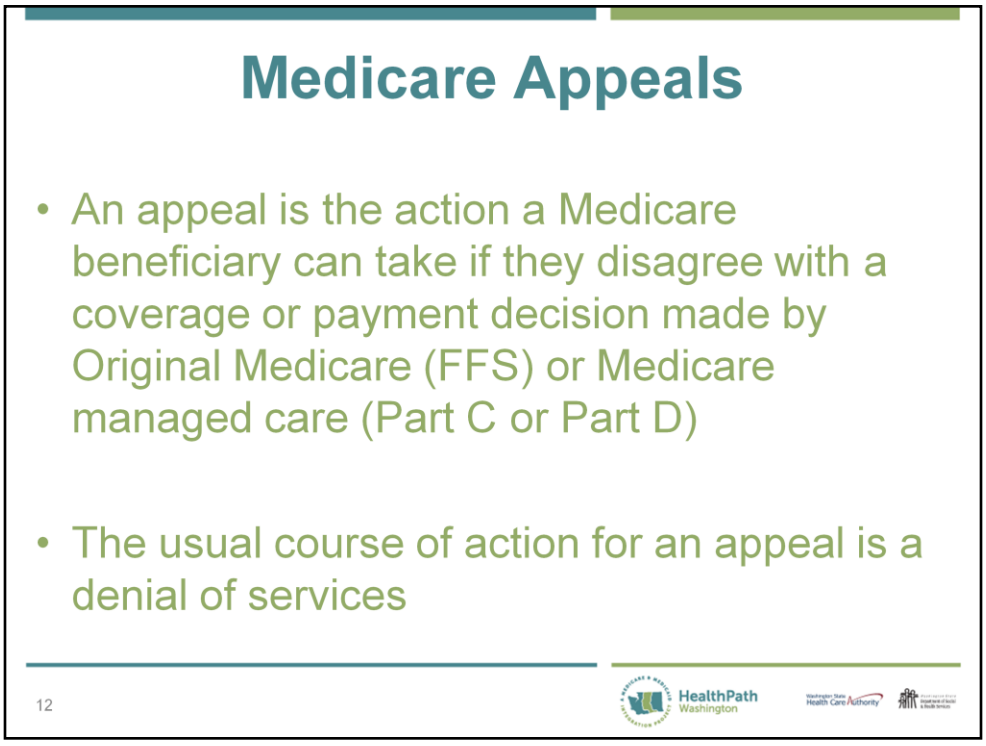
Grievance and Appeals Process
Beneficiary Rights

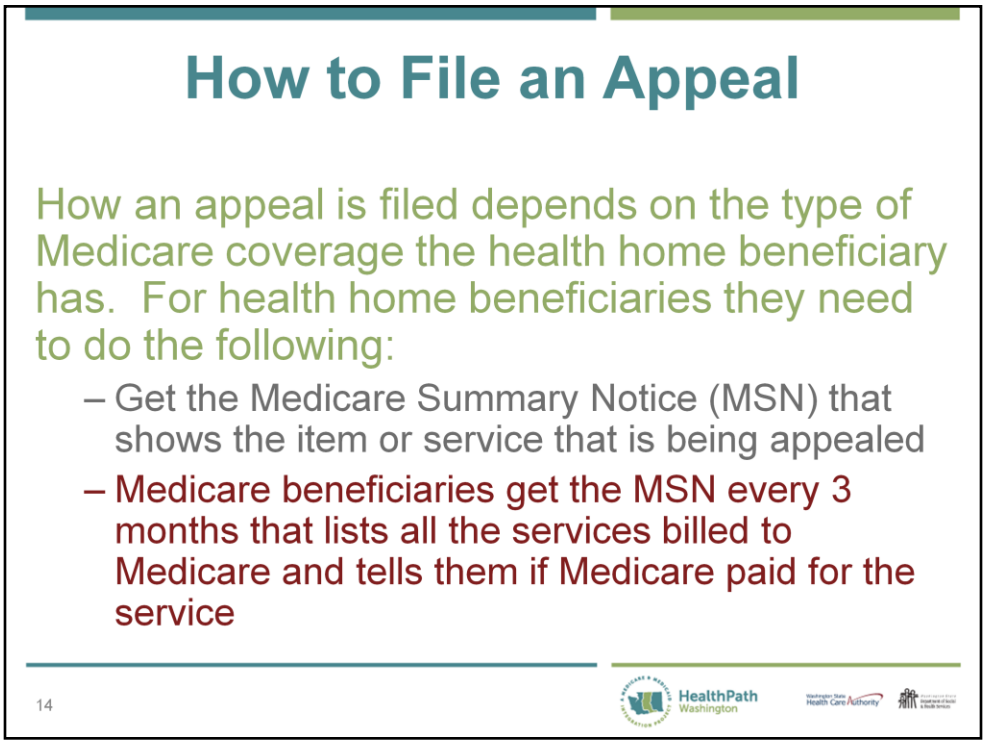


Now to the heart of the slide show – Medicare Appeals. The definition above comes directly from CMS. Usually a beneficiary appeals a denial of a service, but they may also appeal the cost of a service. As a Care Coordinator you may assist a client in seeking services using the Medicare benefit. You may provide education to your client and their representatives about rights and how to file an appeal. You may provide coaching or even complete the required steps to file an appeal on your client's behalf.

Medicare Appeals, cont.

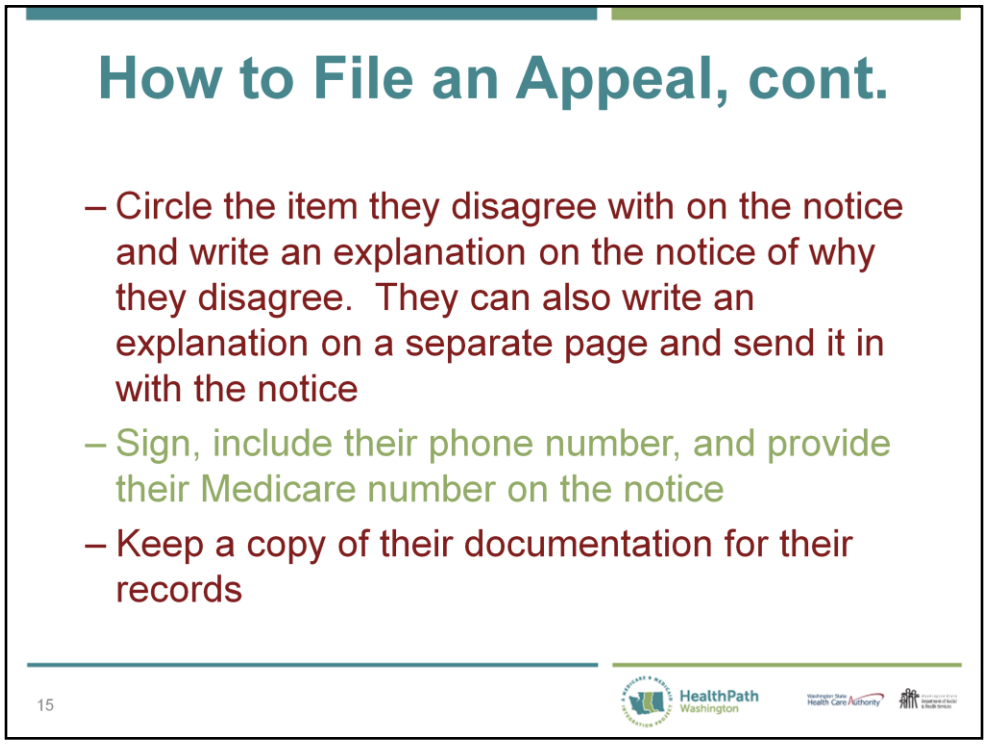
The health home beneficiary may appeal if Medicare denies the following:

- A request for health care services, supplies, items, or prescription drug
- A request for payment for a health care services, supplies, items or prescription drugs they've already received
- A request to change the amount they are paying for a prescription drug
- Medicare (FFS) or Medicare managed care stops providing or paying for all or part of an item or service they think they still need



For example, a beneficiary may file an appeal with their Part C plan or may file an appeal directly to Medicare if they are receiving benefits via Fee-For-Service (FFS). But regardless of whether or not a beneficiary is enrolled in managed care or on FFS, they all receive an MSN.

And, by the way, all of your beneficiaries who are entitled to Medicare appeals are receiving their MEDICAID and MEDICARE benefits through the FFS system, since we don't enroll full duals in managed care and health home services are not available to full duals who receive their care in a Medicare Advantage plan.



Their Medicare number will be on their official Medicare card they receive from CMS.

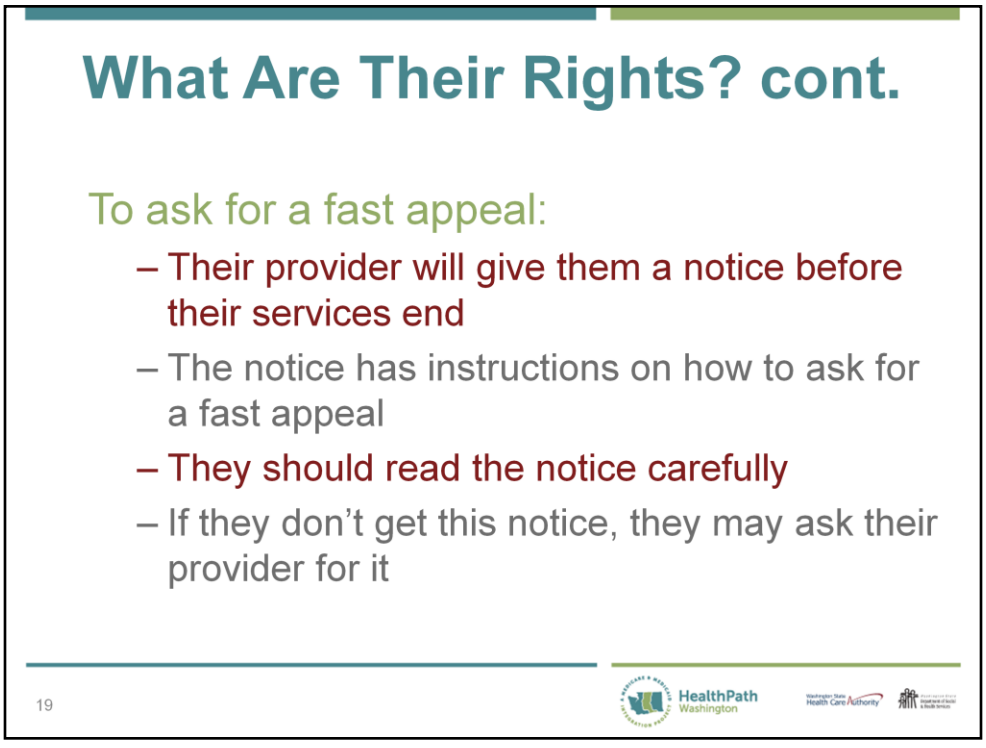
How to File an Appeal, cont.

- Send the notice, or a copy to the Medicare contractor's address listed on the notice
- They can send any additional information they want about their appeal
- They must file the appeal within 120 days of the date they get the MSN
- OR, they can use CMS form 20027, and file it with the Medicare contractor at the address listed on the notice. To view or print this form, visit www.medicare.gov/medicareonlineforms or call 1-800-Medicare (1-800-633-4227) for a copy of the form
- TTY users should call 1-800-486-2048

How to File an Appeal, cont.

- They will generally get a decision from the Medicare contractor (either in a letter or an MSN) within 60 days after the request was received. If Medicare covers the items, it will be listed on their next notice
- The State Health Insurance Assistance Program (SHIP) can also help if they need assistance filing an appeal

In certain circumstances a beneficiary may want to file a “fast appeal.” That means they need to have something resolved sooner than the 60 days it takes to respond or resolve a regular appeal.



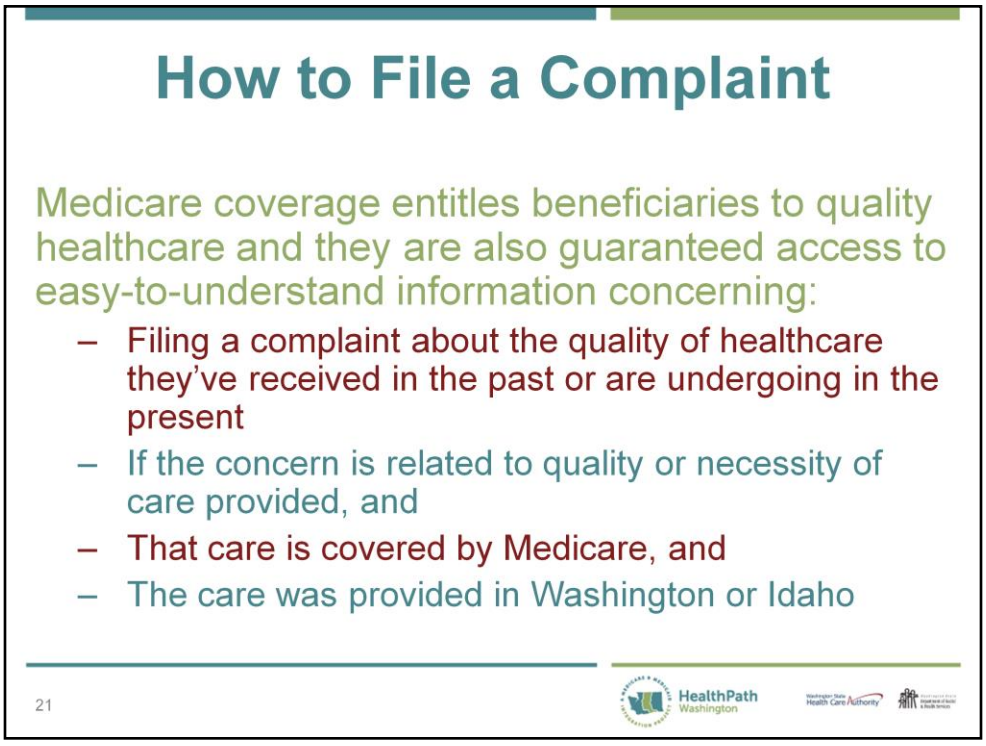
For example, a hospital will give them a notice that they will be discharged before they are actually discharged.

What are their Rights? cont.

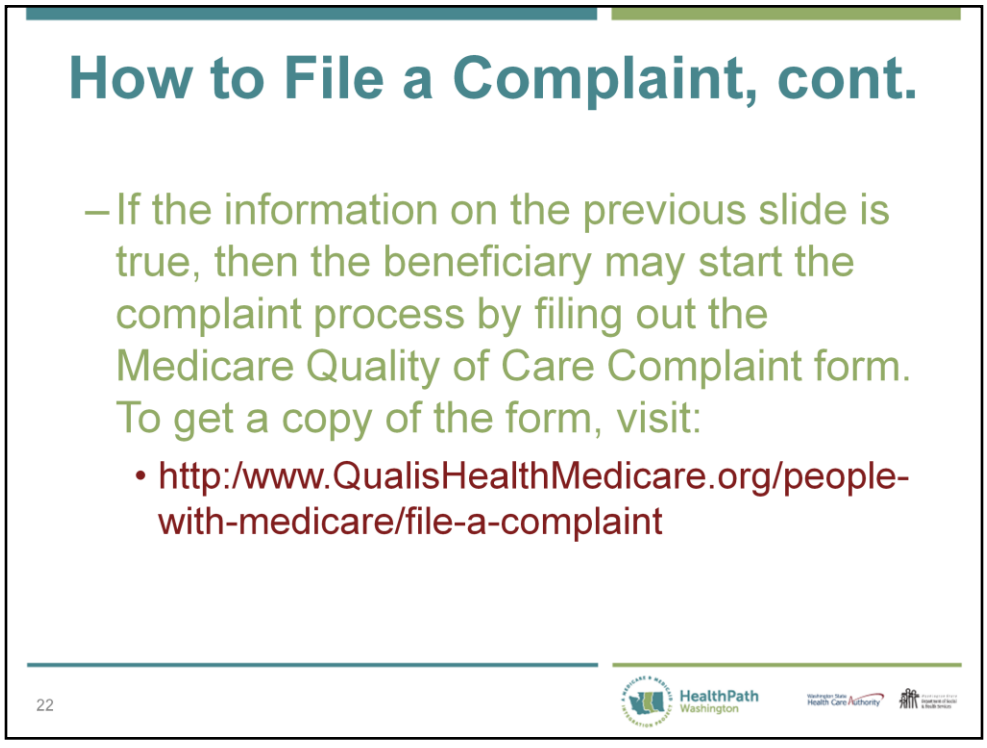
With a fast appeal, an independent reviewer, called a Quality Improvement Organization (QIO) will decide if services should continue

- The beneficiary may ask their doctor for information that may help their case
- They must call their QIO to request a fast appeal no later then the time shown on the notice
  - The QIO phone number is listed on their notice.
- If they miss the deadline, they still have appeal rights if they have original Medicare
- If that happens, they should call their QIO

Qualis is Washington's QIO.



Here is one more additional piece of information on Medicare Appeals and Grievances. A complaint in Medicare terminology is different than an appeal. A complaint is not filed when there is a denial of service or a dispute with payment. For example, a complaint would be filed if a beneficiary doesn't think their doctor prescribed the right drug and they got sicker because of a perceived mistake.



Once they've determined that they've met the criteria for filing a complaint they can fill out a "complaint form."

If you were not able to attend the Webinar held on May 8, 2014 please print this slide then sign and date it after reviewing all of the slides and speaker's notes. Your supervisor should sign to verify completion of this training. Please retain a copy for your records.